pearances, both local and general, resemble those of certain cases of tuberculosis of the peritoneum.

Operation in this class of cases is, as a rule, out of the question. The early formation of metastases forbid interference. Of two patients operated upon by Nicolaysen and Mikulicz, the patients survived the operation. The only record to be found concerning the after histories of these patients consists of the statement that the first was living on the twenty-fifth day after the operation, and the other that he was alive on the fifteenth day. M. operated upon two cases. In one case the procedure advanced no further than an exploratory laparotomy, from which the patient died nine days subsequently. The second case died twenty-four hours following an extirpation of the tumor. The autopsy revealed extensive and advanced metastatic deposits in the liver and omentum.—*Centralblatt f. Chirg.*, July, 1892.

VI. Tuberculosis of Herniæ. By Prof. Dr. BRUNS (Tuebingen). Tuberculosis is the rarest pathological change of a hernia. B. adds one new case to the twelve already published. Of these thirteen the hernial sac was attacked ten times and in seven it was alone the seat of the disease. This, together with other conclusions, substantiate the belief that "tuberculosis of herniæ may occur as a primary disease; generally, however, it is associated with general peritoneal tuberculosis.—*Beiträge zur klin. Chirg.*, Bd. IX., p. 209.

VII. Treatment of Strangulated Herniæ when Gangrene is Imminent. By Dr. THORNHILD ROVSING (Copenhagen). The method, described and recommended almost simultaneously by Graefe and the author, consists in pulling forward the suspicious loop of bowel (having broken up the adhesions) and suturing it to the abdominal wall. The sutures should be of catgut or silk and only include the serous membrane or layer of the bowels. Then dress the bowel with sterilized gauze, wait developments; if the loop return to its normal condition, remove the suture, replace the loop and the interrupted herniotomy is completed. In case, however, gangrene occurs either resect the bowel or establish an artificial anus. The reason that this simple method was not recommended and practiced

earlier was in consequence probably of the fear that the very act of dragging out the bowel might favor the development of gangrene. The two cases of Rovsing and Graefe prove that even very suspicious loops incarcerated for several days may recover under this treatment. —*Centralblatt f. Chirg.*, 1892, July 16.

VIII. Treatment of Gangrenous Herniæ. By Dr. POULSEN (Copenhagen). P. long ago advocated the establishment of an artificial anus instead of resection in case of gangrenous herniæ. He still adheres to this opinion knowing that resection was generally followed by better results, but he claims that the establishment of an artificial anus will yield better results if his own method of procedure be adopted. The technique is as follows: after opening and irrigating the hernial sac, enlarge the incision in the abdominal wall two to three centimetres; then draw out the bowel and suture (through the serous coat only) it to the abdominal wall, so that from five to fifteen centimetres of healthy bowel be exposed. Should perforation occur, close this exposed part with Péan's forceps and wrap in iodoform gauze. After one or two days the loop is destroyed by the thermo-cautery, the enterotome used and enteroplasty performed. P. treated five cases of gangrenous herniæ by the above method. Of these three were cured and two were fatal.—*Centralblatt f. Chirg.*, 1892, No. 30.

IX. Treatment of Strangulated Gangrenous Hernia. By Dr. JULES MARIN (Paris). Primary resection and suture is advocated very decidedly, in the treatnent of gangrenous hernia and the formation of a preternatural anus unqualifiedly condemned. The argument is brought forward that collapse in consequence of strangulation followed by gangrene is rare in strong persons in middle age, and therefore can but seldom contra-indicate enterectomy and suturing. The author describes a procedure proposed by Chaput and Duchamp, the essential point of which is the immediate removal of the spur resulting from an artificial anus, by primary longitudinal splitting and subsequent suturing. After circular resection of the gangrenous portion, with or without cuneiform excision of the mesentery, both open ends